# **Support Plan Audit Form**

**Date of Audit:**

**People** **Reviewing Support Plans:**

**Notes:** This form is to be used in conjunction with the Quality Improvement Activity Report (QIAR) form (see Quality Management Section). Complete the initial part of the QIAR and then collect your data. Once you have completed the audit, summarise the results and complete the rest of the QIAR, including any actions required.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Internal Unique Identification No. |  |  |  |  |  |  |  |  |  |
| Allied Health Professional (AHP) Responsible for the Plan |  |  |  |  |  |  |  |  |  |
| **SUPPORT PLAN FIELD** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **CONTAINS ADEQUATE INFORMATION**  **Y/N/Comment** | **Total Y/N** |
| NAME | SAMPLE DATA |  |  |  |  |  |  |  |  |
| Y |
| ADDRESS | Y |  |  |  |  |  |  |  |  |
| NDIS NUMBER | Y |  |  |  |  |  |  |  |  |
| PREFERRED PLACE OF INITIAL APPOINTMENT  Did the Initial Assessment take place at the preferred place? | Y |  |  |  |  |  |  |  |  |
| Y |  |  |  |  |  |  |  |  |
| PEOPLE CONTRIBUTING TO PLAN Participant, family member, substitute decision maker, advocate  Did the participant or their trusted decision maker participate in the development of the plan? | Participant, Mother, speech pathologist, teacher |  |  |  |  |  |  |  |  |
| Y |  |  |  |  |  |  |  |  |
| DATE OF BIRTH | Y |  |  |  |  |  |  |  |  |
| PHONE | Y |  |  |  |  |  |  |  |  |
| NDIS PLAN PERIOD | Y |  |  |  |  |  |  |  |  |
| DATE OF SERVICE AGREEMENT | Y |  |  |  |  |  |  |  |  |
| REVIEW DATE  Was the Review carried out by due date? | Y |  |  |  |  |  |  |  |  |
| Y |  |  |  |  |  |  |  |  |
| Is this the intended last plan? YES/NO | N |  |  |  |  |  |  |  |  |
| PARTICIPANT’S GOALS (As documented on NDIS PLAN) | To be able to go to the movies with my friends |  |  |  |  |  |  |  |  |
| CULTURAL CONSIDERATIONS & PREFERENCES  Were the cultural needs of the participant respected by AHP? | Y |  |  |  |  |  |  |  |  |
| AHP reported she took off her shoes when in the participant’s home |  |  |  |  |  |  |  |  |
| PARTICIPANTS STRENGTHS | Y |  |  |  |  |  |  |  |  |
| INTERVENTION GOALS to achieve the participant goals above | Y |  |  |  |  |  |  |  |  |
| ACTIONS e.g. Weekly Therapy, Liaison with Suppliers; Equip Trials, Assist Tech Request; School Visit | Y |  |  |  |  |  |  |  |  |
| HOURS /COST | Y |  |  |  |  |  |  |  |  |
| ACHIEVED DATE  Elements of Plan not achieved? | Y |  |  |  |  |  |  |  |  |
| N |  |  |  |  |  |  |  |  |
| REASON NOT ACHIEVED | Y |  |  |  |  |  |  |  |  |
| RISKS IDENTIFIED IN RELATION TO IMPLEMENTING THIS PLAN | Y |  |  |  |  |  |  |  |  |
| RISK MITIGATION STRATEGIES  Evidence risk mitigation strategies were effective  e.g. AHP reported no incidents associated with the risk | Y |  |  |  |  |  |  |  |  |
| AHP reported no incidents |  |  |  |  |  |  |  |  |
| ACCEPTANCE OF PLAN    By Who? | Y |  |  |  |  |  |  |  |  |
| Participant’s mother |  |  |  |  |  |  |  |  |